PUBLIC MEETING
BETWEEN U.S. NUCLEAR REGULATORY COMMISSION O350 PANEL
AND FIRST ENERGY NUCLEAR OPERATING COMPANY
OAK HARBOR, OHIO

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Restate Readiness Assessment Team and Management & Human Performance Phase 3 Inspection Results Meeting held on Friday, December 19, 2003, at 9:00 a.m. at the Administration Building of the Davis-Besse Nuclear Power Plant, Oak Harbor, Ohio, taken by me, Marie B. Fresch, Registered Merit Reporter, and Notary Public in and for the State of Ohio.

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PANEL MEMBERS PRESENT:

U. S. NUCLEAR REGULATORY COMMISSION

John "Jack" Grobe,
Senior Manager, Region III Office
& Chairman, MC 0350 Panel
William Ruland, Senior Manager NRR
& Vice Chairman, MC 0350 Panel
Christine Lipa, Projects Branch Chief
Christopher Scott Thomas,
Senior Resident Inspector
U.S. NRC Office - Davis-Besse

FIRST ENERGY NUCLEAR OPERATING COMPANY

Lew Myers, FENOC Chief Operating Officer
James J. Powers, III
Director - Nuclear Engineering
Mark Bezilla, Vice President/Plant Manager
Mike Roder, Manager - Plant Operations
Barry Allen - Director of Operations

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INSPECTION TEAM MEMBERS - RESTART READINESS ASSESSMENT

Rick Skokowski, Team Leader
SRI - Byron Facility
Dave Passehl,
NRC Region III Project Engineer
Tim Hoeg, Senior Resident Inspector
Granville Nuclear Station
Jerry Blake, Senior Project Manager &
Senior Metallurgic Engineer
Division of Reactor Safety, Region II
George Wilson, Senior Resident Inspector
Duane Arnold Energy Center
John Zeller, Senior Resident Inspector
NRC Region II Office - Vogtle
Jack Rutkowski, NRC Resident Inspector
Davis-Besse Nuclear Power Plant

INSPECTION TEAM MEMBERS - MANAGEMENT & HUMAN PERFORMANCE

Geoffrey Wright, Region III, Team Leader
Clare Goodman, NRR
Julius "Jay" Persensky, RES
Lisamarie Jarriel, NRR
John Beck, Consultant
Michael Brothers, Consultant

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MS. LIPA: Good morning. Welcome to the NRC's public meeting here today to discuss recent inspection findings from two of our inspection teams.

And, I just wanted to make sure everybody knows we have people on the phone lines that have called in today, and so everybody will need to speak clearly into their microphones. Can everybody hear me in the back all right? Okay, I'll try to speak up a little bit.

My name is Christine Lipa. I'm with the Nuclear Regulatory Commission. I'm a Branch Chief out of Region III. What I'm going to do today is introduce the folks up here at the table, go through some opening administrative-type comments for the meeting, and then I'll turn it over to the first inspection team, for them to introduce their members and give their findings; and then we've have the second inspection team.

We'll be taking a break about every hour to an hour and a half. So, that's kind of the order of activities for today. And then, we will be having time before the meeting is adjourned today, after the business portion is adjourned, we'll be having time after that for public comments and questions; both from people here in the room and from people on the bridge lines. So, that's kind of the overview of what we're having this morning.

Okay, so, up here for the NRC folks that are at the table, we have Jay Persensky, who is a member of Geoff Wright's team and Geoff will introduce his team more fully later. Geoff Wright is the Team Leader out of Region III for the Management and Human Performance Phase III Inspection.

And then to my right, I have Scott Thomas. He's the Senior Resident Inspector here at Davis-Besse.

To my left, I have Bill Ruland. He's a Project Director out of NRR. He's the Vice Chairman of the panel.

To Bill's left, we have Jack Grobe. Jack Grobe is the Chairman of the 0350 Panel.

Then, we have the inspection team, Rick Skokowski is the Team Leader for the Restart Assessment Team. And Rick will introduce, and have his team members introduce themselves in a few minutes.

I also wanted to acknowledge Jan Strasma is here, he's the Public Affairs Officer of Region III, in the back.

There were a couple of handouts when you came in this morning. One of them is a feedback form that you can use to provide feedback on how this meeting is working today, and what you got out of it and any comments you have for us.

We also will have at one of the breaks, you can get

up, there is a handout for Geoff Wright's team, which will be second. So, you don't need to run for your handouts now, you'll have time at the break to get those.

The first inspection team results, we do not have a handout for that, so you'll have to just listen carefully.

This is what we consider a Category One Meeting from the NRC's classification of meetings. That means it is a business meeting with FirstEnergy and there will be time for public comment and question before the meeting is adjourned.

We have a transcriber today. And this meeting will be transcribed. The transcription will be available within about 2 to 3 weeks on our web page. Because we have a transcriber, because of the people on the bridge lines, I want to emphasize how important it is to speak into the microphones today.

And that's really all I had for now. I'll go ahead and turn it over to Rick to introduce his team.

MR. SKOKOWSKI: Thank you, Christine.

Good morning. As Christine said, my name is Rick Skokowski. I was the Team Leader for the Restart Readiness Assessment Team Inspection. I'm currently the Senior Resident Inspector at the Byron facility run by Excelon; prior to that I've been the Resident at the Fitzpatrick

Plant run by Entergy most recently, before that New York Power Authority; and prior to that I was Resident at Niagra Mohawk, Nine Mile Point 1 and 2.

I'll go to Dave Passehl.

MR. PASSEHL: Hi, I'm Dave Passehl. I'm currently the Project Engineer at NRC Region III. Prior to that, I was a Senior Resident Inspector at Callaway Plant in Missouri, run by the former Union Electric Company. Prior to that, I was a Resident Inspector at Palisades run by Consumers Power. I was also prior to that the Resident Inspector at D.C. Cook run by American Electric Power.

My primary assignment for this current inspection was to assess QA's involvement in Restart Readiness.

MR. HOEG: Good morning. My name is Tim Hoeg. I'm currently the Senior Resident Inspector at the Granville Nuclear Station in Port Gibson, Mississippi. That's a Region IV Plant. Prior to my assignment at Granville, I was a Resident Inspector at Calvert Cliffs Station in Maryland owned and operated by at the time Gulf Core Gas and Electric.

My primary responsibility for the Restart Readiness Inspection was Engineering.

MR. BLAKE: My name is Jerry Blake. I'm a Senior Project Manager and Senior Metallurgic

Engineer from the Division of Reactor Safety in Region II. I've been with the Division of Reactor Safety for 28 years and during that time I've been a supervisor, I've been a Team Leader on a number of Restart, Accident Investigation, Maintenance, and Engineering Evaluation Team Inspections.

My part of this inspection was observing Maintenance's support of Operations.

MR. RUTKOWSKI: My name is Jack Rutkowski. I'm a Resident Inspector here at Davis-Besse since June of last year. Prior to joining the NRC, from the period of 1986 to the period of 1996, I was Assistant Plant Manager at the Donald C. Cook Nuclear Power Plant. After that, I was a Senior Internal Consultant working out of Organizational Development Organization in American Electric Power's corporate office in Columbus, Ohio.

My primary responsibility for this inspection was Configuration Control.

MR. ZELLER: Good morning, my name is John Zeller. I'm the current Senior Resident Inspector out at NRC Region II Office down at Vogtle, which is owned and operated by Southern Nuclear Company. Prior to that I was a Resident Inspector at H. P. Robinson, who is operated by Progress Energy. Prior to that, I was a Resident Inspector at the Catawba Station, which is owned and operated by Duke Energy down in South Carolina.

My primary responsibility during this inspection was to look at Surveillance Testing.

MR. WILSON: I'm George Wilson. I'm presently the Senior Resident Inspector at the Duane Arnold Energy Center, operated by the Nuclear Management Company. Prior to that, I was a Resident Inspector at the LaSalle Nuclear Plant operated by Excelon. Prior to that, I was an Operator Licensing Examiner in Region III. And prior to that, I was a Senior Reactor Operator and I&C Supervisor for TVA.

My primary responsibility during this inspection was to look at the assessment of Operations.

MR. SKOKOWSKI: Lew, do you want to introduce the main players of your team?

MR. MYERS: Let me take a moment now.

First to my right is Mike Roder. Mike Roder is our Operations Manager. Mark Bezilla, to my left. Mark is the Site VP. Barry Allen, the Director of Operations, is beside him. And then, Jim Powers is at the end of the table. He's our Director of Engineering.

We also have some people in our audience today. Fred von Ahm, VP of Oversight, is with us; the Senior VP of Engineering and Services, Joe Hagan is here with us. Gary Leidich, the President of FENOC, is also with us.

MR. SKOKOWSKI: Thank you.

As I said, this is the Exit Meeting for the Davis-Besse Restart Readiness Assessment Team Inspection. The findings will be documented in Inspection Report 2003 Number 11.

MR. GROBE: Rick, excuse me.

Lew, did you have any opening remarks you wanted to make?

MR. MYERS: Well, I had thought about, some thoughts before the meeting. As you know, the purpose of this meeting is to discuss our recent plant operations and our Operations group, if you will, and then finally the Management/Human Performance Building Blocks.

We had a debrief over the past few days of findings that this team has had. And, you know, one of the comments I would make, this is a very strong team that you brought in, one that I have been able to understand very clearly. So, you know, from a standpoint of their issues, they don't have any issues that I've heard that we don't understand and we don't agree with. So, going into the meeting, let me say that.

Our operators, in general, what we see is our operators are not having events. Let me be clear of that at the very beginning of the meeting. And consistently,

when faced with abnormal equipment operating issues, have shown a consistency to provide safe and comprehensive and conservative operations. They stop, put the plant where they need to, equipment where they need to, and troubleshoot in places they need to, you know.

In general though, what I think this team is seeing, what we're seeing as a management team also in both our management observations and our industry observers, is that we have not consistently performed our routine operations in a manner that, that's consistent. We need to continue to improve there before we start the plant up.

For example, let me use some examples of what we're seeing, is that, we're not consistently seeing the requirements of our Conduct of Operation nor our Prejob Briefs consistently being implemented. The management tools that we use to ensure that activities go off as planned, are not consistently being implemented in our Operations group.

As you know, we're planning a meeting on December the 29th to discuss the results of the Safety Conscious Work Environment that we'll discuss later. And at that time, I think we will be ready, it's our intention to be ready, to not only discuss the Safety Conscious Work Environment survey that we recently took, but the actions we're taking and going to continue to take in Operations to

ensure that we have consistency in our day-to-day operations.

And, in closing, once again, we were debriefed by this team, for what, four hours last night. And this is a very fine team. We're seeing the same things you are. We won't heat the plant up until we're ready. We won't start the plant up until we're ready. I don't think we have any disagreements from FirstEnergy today on the issues that you, that we've heard from you. Okay?

MR. SKOKOWSKI: Understand. Thank you, Lew.

I do wish if there is any questions regarding the inspection findings and observations, that you hold them until I finish going through the results.

The purpose of this inspection was to evaluate the readiness of the Davis-Besse Plant's hardware, plant staff, the management program to support restart.

Based on our review, the plant's failure, the failure of your staff to consistently implement expectations and standards do not give us reasonable assurance that you would be able to adequately operate the plant at power without additional observations on our part.

These consistencies were noted in several areas. First -- and I'll go through a list of the different areas

and then provide some details regarding why these areas showed inconsistencies.

Several examples of deficient Prejob Briefs indicating a lack of preparation for plant activities. Several examples were noted where operators lack awareness of plant equipment and plant status. Several examples were noted where the operators were not following management's expectations and written standards.

On occasions, Work Control appeared to be disorganized and there appear to be a lack of project oversight to ensure proper rigor in the Work Control Process. There were several schedule changes that occurred. They may have contributed to some of the problems that we observed during this inspection.

We noted that several system engineers for safety-related systems were not qualified for their assignments. We had concerns regarding traceability of test equipment. We saw examples where procedure quality and procedure adherence was inadequate. And we had some examples where Corrective Actions resulting from the operational performances issues in September were either not tracked or were ineffective.

Regarding Prejob Briefs, we did observe the Prejob Brief for a positive safe pump start. During that brief, we noted that the operators did not adequately address all

the special precautions and limitations described in the subject procedure, nor did they address any of the limits associated with tripping the pump. These issues were only addressed after the inspectors brought it to the test controller's -- or to the, to the operator's attention.

We observed the Prejob Brief control of a bubble in the pressurizer. This brief did not cover all the applicable propulsions and limitations, nor did it address the fact that there was out of service equipment, including a pressurizer instrument needed to be used by the procedure, and that there were a number of issues tied to the pressurizer heaters that would have made them out of service.

We observed the Prejob Brief for the Full Float Test in the Train One of the Aux. Feedwater System. We noted that the test controller failed to recognize that additional test equipment was needed to be installed to monitor one of the Aux. Feedwater Flow instruments. The reason this test equipment was needed was to determine the cause of a past problem.

Once the inspectors brought this issue to the test controller's attention, the Licensee stopped and placed the test on hold to evaluate the need to install this test equipment. They brought in the System Engineer, discussed it, and made the determination that it was not needed to

use the test equipment.

The test went on; and during the test, again, some insignificant flow oscillations were identified on the associated Feedwater Flow instrument indicating that the problem was still there.

We also observed the Prejob Brief for the Train Two Aux. Feedwater Flow Test. Again, we noticed that the Prejob Brief failed to address specific, one particular specific propulsion associated with the test that had to do with opening the steam emission valves slowly to ensure -- or to prevent a water valve condition.

Additionally, during the preparation for the assigned Prejob Brief, the test controller failed to adequately review the past test associated with this system. The results in, this resulted in the need to abort the test, because during the test you were unable to meet the specified minimum recirculation flow for the pump.

Had the test controller reviewed past tests, they would have identified that during the last two test performs, performed on that system, that you weren't able to obtain the minimum recirculation flow, and they would have had the opportunity to assess the condition and change the procedure prior to running the test.

These several examples associated with Prejob Briefs are important; and Prejob Briefs in general are important

because they allow the operator to understand the upcoming evolution and it also ensures timely completion of the evolution, which during online maintenance would minimize the unavailability time of the equipment.

Furthermore, these Prejob Brief concerns were similar to concerns that were identified with your operational problems back in September. And you were taking corrective actions to attempt to correct these issues, and it appears as if they were not totally effected. These issues associated with Prejob Briefs are being considered potential violations of your Tech Spec regarding Procedure Adherence.

Indications where the operators lacked awareness of plant equipment and plant status --

MR. MYERS: Can I ask you a question, for clarification? Did you see, you saw some places where the Prejob Briefs were not as effective as they could be, but did you see any good Prejob Briefs?

MR. SKOKOWSKI: Yes, we did see some examples of good Prejob Briefs and there was some improvement over the course of the inspection, but again, for the consistency wasn't there, and expectations should be followed out a hundred percent of the time.

We'll try to keep the questions until the end, if we could.

MR. MYERS: Okay.

MR. SKOKOWSKI: Thank you.

Again, back to indications where operators lack awareness of the plant status and what the status of their equipment was. We witnessed the evolution of drawing a bubble in the pressurizer. The operators did not realize there was an interlock associated with the heaters and Safety Actuation System.

And in the configuration the plant was in, during the evolution, there was one channel of the Safety Features Actuation System out of service, and this would result in some of the heaters not being capable of operating. Therefore, when the operators went to turn the heaters on in accordance with the procedure, the heaters did not energize.

Furthermore, the operating crew did not know that there was no power available to the variable control heaters because the associated motor control center breaker was tied out. The motor control center would provide power to all these heaters.

There was no indication on the, in the control room, one controller, there was no power to the, these heaters, and when the operators attempted to operate the heaters via the controller, there was no response.

Another item was, during a morning turnover meeting

on Sunday, the 14th of December, the shift manager did not have a proper understanding of the plant conditions; particularly two pieces of important safety equipment. The status of those equipment was unknown or incorrect by the shift manager, and that was the Number One Train of Decay Heat Removal and the Number One Train of the Emergency Diesel Generator. They were both inoperable, and the shift manager thought they were operable.

In addition, the shift manager reported the risk to be at a baseline risk or green risk, when actually it was slightly elevated, what would be considered a yellow risk by the plant.

Later that morning, senior management did have the shift manager removed from the watchstanding duties for further evaluation, which was the appropriate actions.

Another example was, during the time test of a service water valve, the operators did not understand that the associated interlock requiring the service water valve to be open as long as a fan was running. This was evidenced in that the operators did not anticipate that the valve would automatically reopen when it was stroked during the testing evolution, because the fan was running when they did the test.

Again, these issues are similar to issues that were identified with the operational problems you had back in

September; and again, you were supposed to have taken some actions to attempt to correct these issues, and again, they did not seem to be totally effective.

These issues associated with plant awareness are also being considered potential violation of your Tech Spec regarding Procedure Adherence.

Regarding operators not following management expectations and written standards, we had a number of observations regarding alarm responses. Items like shift managers acknowledging and silencing alarms instead of maintaining their role as command and oversight.

An operator assigned to silence a recurring nuisance alarm took it upon himself to lean against the alarm panel such that he was keeping the alarm silenced and also any other alarms that could have come in would not have been audibly recognized.

Other items would have been not knowing whether an alarm that was received was expected or not; and then if it was not known to be expected, not following through to look at the alarm response procedures.

Moreover, these issues have been identified by other outside organizations as an area that should have been improved.

We did see items associated with Procedural Adherence. Items like not routinely completing the end of

shift critiques. Also, other operators were unaware of the cognitive operator procedure requirement to mark on the chart orders whenever a bump was started associated with that system.

We also noted a supervisor that went through a door that was posted "Contact security prior to going through this door." The individual did not do that; and when challenged, tried to justify his possession in that, saying that he only needed to call security if he did not get the proper indications. After being challenged again, acknowledged that what he had done was wrong.

In general, the need to implement management expectations and standards are an important tool to ensure that the activities completed are done properly. And this is another example where there was issues similar to this back in September during your operational events that you had taken some corrective actions, but again, were not as effective as they should have been.

These issues are also being considered potential violations of your Technical Specifications for Procedure Adherence.

On occasions, we did note that Work Control appeared to be disorganized and there appeared to be a lack of management rigor in the project oversight to ensure the proper rigor in the Work Control Process.

We also did see this show up with respect to moving things up into the schedule and change the schedule around, which may have impacted some of the other activities going on in the plant and added to the problems that we have noted before.

And this was supported by numerous observations during Work Planning Meetings, Prejob Briefs, Shift Turnover Meetings, and Plant Evolutions where members of the staff seemed unorganized and uncertain of the status of the activities.

We also noted that valve line-up verifications that needed to be complete weren't shown in the schedule, which makes it difficult to understand where all your resources are.

During the turnover of the night on September 13th, the Operations Department failed to ensure that all expected watchstanders knew to show up on site, knew they had duty that night. That meant that there was two operators their reliefs didn't show up. Although, the technical specification requirements for manning were always met. This was an unexpected situation. Additional operators were either called in or brought in from other activities on site at the time. But, but this impacted the number of expected resources to complete tasks that night. So, again, from a Work Control Process, made things more

confusing than they should have been.

Again, the significance of adequate Work Control allows for equipment being taken out of service to be, work efficiently such that you would minimize the unavailability problem of any safety-related equipment.

There are no violations associated with this area with respect to Work Control.

Another area we looked at was System Engineering and particularly the system engineers or system, safety-related systems not being qualified for their assignments. And this was evidenced by the fact that the primary and back-up system engineers for some safety significant systems, such as Aux Feedwater, High Pressure Injection and Low Pressure Injection were not qualified by your training program for those positions.

Furthermore, there was no system engineer on site trained or qualified in accordance with your training program for the motor driven or startup feedwater pumps.

Although these individuals filling the positions were competent, the failure to qualify these individuals by your program could impact their ability to understand your systems and processes and is being considered a potential violation of your Tech Specs regarding Plant Staff Qualifications.

Additionally, during our review of the System

Readiness Affirmations, we noted that several of the safety-related systems were system affirmations for having the systems ready for Modes 1, 2, 3 and 4 were completed by nonqualified system engineers with no reviewers or no peer checks. We do note that subsequent that these affirmations were reviewed by qualified engineers.

Our next concern was associated with the traceability of test equipment. We noted that out of 34 pieces of test equipment used in some surveillance tests that we reviewed, we identified eight that you did not have traceability tying the test equipment back to the completed test.

Additionally, procedures controlling test equipment require a travel form to be issued with the test equipment to record each of its uses if more than one use is expected. However, the practice was that the issuance of a traveler was optional, was only used if the, was requested by the user or if the user did not know which parameters the equipment would be used on.

The impact of this concern is that this equipment post-calibration reports that would come back out of cal, you would then need to go back to determine what tests were impacted by using out of cal equipment on it. It was without having good traceability, it would be next to impossible to determine which surveillance tests were

impacted.

We did note some additional concerns associated with your Test Equipment Program. They were a lack of a formal process to control or prevent the use of the same piece of test equipment on false training tests. And a concern here is, if you had a piece of equipment that used on train one, use the same equipment on train two, and you did the post-testing calibration, that you would have both of those train and it came back unSat, you could have both trains in an inoperable condition.

We also noted that your program does not define critical use applications for test equipment where immediate post calibrations were required. This was only utilized on certain ASME Code applications. And we also identified that your Test Equipment Program Procedure had been misqualified as a quality procedure versus a safety-related procedure. And that would be addressed by your staff.

Again, the importance of these concerns, of the post-calibration reports, if they came back saying that a piece of equipment would be out of calibration, it would be very difficult to go back and determine which equipment that surveillance, or which equipment would be affected by those out of cal test equipment.

These issues are being considered potential

violations of your Tech Spec on Procedure Adherence.

We also noted a number of examples associated with Procedure Quality and Procedure Adherence. During the Full Flow Test of train one of the Feedwater System, the test was supposed to check the reverse flow function of some selected check valves. The valve lineup for this test was incorrectly established to ensure this evolution was completed properly; and, therefore, the check valve was not tested; and one particular check valve was not tested as designed by the procedure. Since this mispositioned valve was a locked valve, it also indicated some concerns associated with the Lock Valve Program.

During the Valve Stroke Test, the Service Water Valve 1366, there was other issues with that procedure, particularly this procedure was written to allow partial use of completion; and it was inadequate for that process as evidenced by the test that was performed.

When the test was performed, the associated fan was running, and when the operator performed the test, the associated service water valve, what closed as according to the test, but then unexpectedly reopened. This was due to the fact that the procedure, which required that the fan be off in the first section of the procedure, did not similarly reference the need in the second section of the procedure to ensure the fan was off. The second section of

the procedure is the one that was done to test the valve, Service Water Valve 1366. If the procedure would have been written properly, this problem would not have occurred.

We also noted during just in time frame, that one of your operators had identified that the heatup had a deficiency in that it specified Reactor Coolant System pressure and temperature limits that could have allowed you to possibly operate without the required positive suction head for reactor coolant pumps.

We do know that you identified this in preparations for training, and the scenarios over in the simulator; however, it was not identified during your Procedure Change Process.

We also identified that there were periods of time where train two protected equipment, particularly all the aspects of the division train two emergency diesel generator, and again, the particulars were the air receiver tank room, the door for that, the door for that room was not protected in accordance with the expectations in your program and it ended up being due to the fact that one item was not explicitly called out in the associated procedure.

Another item we noted with respect to Procedure Adherence was during the post-mod testing with the hot checks of the breaker for the service water two strainer, strainer motor leads were lifted, but they were not

controlled in accordance with the lifted lead sheet as required by your procedure.

These issues regarding Procedure Adherence and Compliance are considered potential violation to the Tech Specs on Procedure.

We also noted areas where the Corrective Actions operate resulting from your operational performance issues back in September of 2003, were either not tracked or they were ineffective. There were several cases as I've already described regarding prejob briefs, awareness of plant status and activity, and follow through management expectations, all came into play with your events back in September. It's obvious that the Corrective Actions were ineffective and more needs to be done in that area.

We also noted that there were several recommendations from your Licensee's assessment of the heatup to NOP/NOT back in September that were documented in your Assessment Reports. These actions were either not tracked or not completed; and, we understand there may be some more information to follow regarding that area and we will be looking at that.

Currently, both of these areas indicate potential violations of 10 CFR Appendix B Criterion 16 associated with Corrective Actions.

They were the major areas we had indications of

concerns. We did have some other more isolated items I would like to talk about. One, having to do with problem identification and particularly deficiencies on the, some of your Emergency Core Cooling Systems were identified by our inspectors that weren't picked up by your staff, even though they had already done their System Readiness Review Walkdowns for the systems.

The first item was, we had identified that a spring can on the discharge piping of the operating gate removal pump was under compression and reading off scale indicating that the spring may not be capable of performing its function.

The inspectors brought this to the attention of the system engineer, and only after several attempts by the inspector did the system engineer bring the issue to the attention of the control room.

Because of the potential of this concern, this concern had on the operability of the operating equipment, this issue should have been immediately brought to the attention of the shift manager for assessment.

After subsequent review, it was determined that the concern with the can ended up not being an operational or operability concern, although it was not what we expected.

Additionally, the inspectors identified two issues associated with an inoperable train of high pressure

injection, particularly that a unistrut was missing bolts from where it connected to the floor and that the DC lube oil pump junction box was broken, peeled back such that you could see some of the wires inside the junction box.

These failures to identify concerns are potential violations of 10 CFR Appendix B Criterion 16 Corrective Actions.

We also noted some issues with a particular work order. There was a work order that was revised and ended up indicating work to be done on the wrong train of high pressure injection. Your staff had initiated a CR after identifying this, particularly that the work instruction issue for work on November 2nd, with the High Pressure Injection Pump A should have been issued to work on -- let me start that over.

That it was issued for work on the Number Two High Pressure Injection Pump, but it should have been written that it was issued for work on the Number One High Pressure Injection Pump.

During the evolution, work was performed on the correct pump, but the questions that came up were, "Why did so many people review this work order and approve it when it was indicating work to be done on the wrong piece of equipment?"

This is a potential violation, again, of 10 CFR 50

Appendix B Criterion 16 Corrective Actions.

The last item had to do with our review of some completed work orders involving the installation of cable splices. We noted that not all installations were being reviewed by your QA -- or QC Organization. Follow-up review of this issue indicated that there were some QC inspections that were, and associated decisions with these inspections that were not well documented.

We did have one other area, that was the area of ladders. We did see a number of places where ladders were not tied off in accordance with your procedures. We brought this to your attention and they were corrected in every case.

There were some areas that looked acceptable; particularly control room operators use of communications. They consistently used three-way communications. They used the phonetic alphabet consistently. Peer check were used consistently. There was good use of self-checking of your Star Process. And they did a very good job controlling control room access.

We did note that the support from Engineering to Operations, Engineering had installed a process to ensure they provide timely response to Operations' concerns. We did see this in work. And based on the discussions with your Operations staff, they believe it also was working.

We thought the performance of your nonlicensed operators was very good. And the general overall plant material condition was good.

In conclusion, the failure to consistently implement expectations and standards did not give us reasonable assurance that the Davis-Besse plant was ready to adequately operate at full power.

In addition, based on our observations, we had questions regarding the effectiveness of the Corrective Actions require operational concerns, which will require further assessment by your staff and should include an understanding of why past Corrective Actions were ineffective and why the new Corrective Actions will be more effective.

This effort will be needed to, to determine whether the readiness of the station to make the transition back to full operations.

As always, with these Exits, that the classification of the findings is still up to my management's discretion. Thank you for your attention. And are there any questions?

MR. GROBE: Before we go to questions, Rick, thanks. Let me make a couple of comments and observations.

First, I want to recognize the fine work that this team did, and also express appreciation for their

management around the country for making them available to us.

Christine and Rick pulled together an outstanding team with experience, as I was listening, upwards of a dozen different nuclear plants, assessing operational performance, of about a dozen nuclear plants around the country. Hundreds of years of experience of operational assessments sits up at this table. They did an outstanding job performing this inspection; worked continuously for the last twelve days, including day shift, night shift, round-the-clock activities, observing Davis-Besse's performance.

As Rick indicated, these are preliminary inspection findings. We wanted to provide this information to you on a timely basis. The inspection actually was continuing through this morning, and additional information was gained.

Consequently, it is possible that these findings will be further refined and could change. If they do, we will inform you of that, before the report is issued.

Similar to the findings of our inspections of your Normal Operating Pressure Test in September/October, this inspection revealed that there were no safety issues. That your operators performed sufficiently, that the plant was not a safety risk. However, there were areas of violation

of NRC requirements and your operating organization did not perform consistent with your standards and expectations.

The team was concerned, as Rick expressed, about these inconsistencies in your performance. The team briefed the panel on the results of their inspection, and we spent quite a bit of time considering these results.

The panel's conclusion was that we need additional information, prior to the panel being able to assess whether it would have reasonable assurance that the plant could be operated safely and in compliance with the NRC regulations and your license.

Previously, the meeting on December 29th, was anticipated to be the Restart Meeting. And that was always contingent upon ongoing inspections and evaluations. Now understand and appreciate that, that you expect to be able to prepare information for us, that we need to understand your assessment of the causes of these violations and inconsistent performance; your evaluation of the reason that the prior Corrective Actions taken after the Normal Operating Pressure Test activities were not fully effective; what further actions you believe are necessary to improve compliance and consistency in performance; why you believe those actions will be more effective after the Normal Operating Pressure Test; how you will assess the effectiveness of those actions prior to requesting

rescheduling of the Restart Meeting.

So, those are the activities we expect you to be ready on the 29th to discuss with us, and we look forward to that meeting. I believe that meeting is scheduled at Oak Harbor High School at 6:00 in the evening.

Is that right, Christine?

MS. LIPA: That's correct.

MR. GROBE: Very good.

At this point, I would like to turn it over to you, Lew, for any questions or comments your staff has.

MR. MYERS: I think that once again, there is nothing here, we're seeing the same indications. There is nothing here that I saw yet that we disagreed with.

I would say that, you know, if you look at the, you mentioned that the safety significance here, you said no safety significance; is that right?

MR. GROBE: Yes.

MR. MYERS: And our operators are continuing to, when presented with problems, to behave very well.

These management tools that we have in place are designed to ensure that we understand what should happen when we start this equipment.

The other thing I would say, I appreciate the kind

remarks on our nonlicensed operators, but a lot of these issues that you did bring up are not in my mind the nonlicensed operations found. The ladders in the field, they're responsible for the facility, for a strut being broke or the, or there was another one too, but I expect these guys to find these things, you know. They're the facility manager for their facility, what they have to do.

So, the performance we've seen there does not meet our expectations, and we're going to work hard to increase that, that adherence to our standards. You know, we're going to work very hard on that the next few weeks. We think we can, in a timely manner, make the adjustments we need to so it's consistent, with Mark in charge and stuff with our other plants.

We're going to get this stuff consistent. We're going to take hard actions. We're going to hold people accountable, but we're going to make sure that we're ready to restart the plant, and that we can do that shortly. And we will not come to you and ask permission to restart the plant unless we're comfortable that we're ready to restart this plant. And this team needs to understand that. So, that's all.

Do you have anything, Mark?

MR. BEZILLA: Nothing to add, just reiterate what Lew said, is that we won't heat

the plant up and we won't restart the plant until we're ready and make sure our people are ready.

I would like to thank the team. I think they did a real good job. Sometimes it's not always easy to relish the feedback, but you guys did a real good job and you will help us be better, my teammates and myself. So, we appreciate that.

And, Jack, we'll find out why we weren't as effective as we could have or should have been, and we'll get this squared away.

MR. MYERS: The only comment I would make, we thought before this team got here, that we would have all the equipment issues, we had about seven days and some of our equipment issues went longer than expected, but that's no excuse. So, we didn't have the seven days or week or so to prepare that we should have, but that's no excuse, because we should be prepared all the time. So, we're just not satisfied with this performance. We'll take the actions that we need to.

MR. GROBE: Okay. Thank you very much.

MR. MYERS: Let me add this too. You know, sincerely, you know, you have these comments all the time, you know, we thank you for being here and you don't mean them, but we really mean it. This

was an outstanding team. We think their comments are good, and we enjoyed having you guys here. We think you did a really good, good job.

MR. GROBE: Rick, any other comments?

MR. SKOKOWSKI: No.

MR. GROBE: Any other comments from the panel?

I think what we would like to do is take a very brief break. That doesn't mean get up and go out in the hallway, that means just give us a few minutes to change our teams up here, and then we'll proceed with the second exit. Thanks.

MS. LIPA: But we would like to give everybody a chance to get handouts in the hallway, so we'll probably need about ten minutes.

MR. GROBE: Okay, thank you, Christine.

(Off the record.)

MS. LIPA: Okay. I want to make sure we have the bridge lines back on.

Okay, bridge lines are ready. And, what I'm going to do now is turn it over to Geoff Wright to introduce his team and his inspection results.

MR. WRIGHT: Thank you,

Christine.

Good morning. My name is Geoff Wright. I am the Team Leader of the Management and Human Performance Inspection Team.

I am going to hold just for a minute introducing the rest of my team with the exception of Jay Persensky, who is on my right. I'll have a little bit additional, but I wanted to give Lew a chance if there are any different players that you would like to introduce.

MR. MYERS: I don't think so. I think we're okay.

MR. WRIGHT: Okay. What I would like to do is describe first what the scope of our inspection activities were to give you some sort of a framework when I introduce the different team members, so you can see the relevance and the experience that this team brought to this effort and you'll have an ability to look at it in that perspective.

The purpose of this particular meeting is to provide you with the results of the third phase of our Management and Human Performance Inspection. For those of you who may not be familiar with this inspection, I would like to briefly review the inspection plan with you.

To facilitate the entire scope of the work that we envisioned for the Management and Human Performance Area,

we divided the inspection into three phrases.

Phase One: Assess the techniques and results of the original Root Cause Analyses into the Human Performance Contributions to the degraded reactor vessel head.

Based on our review of the root causes for Management and Human Performance at that time, we concluded that the completed reviews had been appropriately conducted and provided meaningful insights; that planned Corrective Actions, if properly implemented, were sufficient at that time.

The team identified that additional assessments in the area of Engineering, Operations, Nuclear and Corporate Oversight Activities were necessary. The team also identified the Collective Significance Review of the individual area assessments had not been performed.

At the time we exited on Phase One, we could not conclude whether the Corrective Actions identified to-date were sufficient until additional, the additional assessments I just mentioned were completed, and the Collective Significance Review had been accomplished.

We came back after those assessments had been completed, and identified that indeed they had been appropriately completed and that the Corrective Actions that were associated, if as I said were implemented properly and monitored, should prevent recurrence of the

problem.

The Phase One results are documented in Inspection Report 2002-15.

Phase Two of our assessment looked at the appropriateness of the Corrective Actions against your causes and implementation of those Corrective Actions through the original evaluations.

Our inspection concluded that, again, if properly implemented and monitored the Corrective Actions would appropriately address the issues identified in the assessments, and that the scheduling and implementation of the Corrective Actions had been appropriate.

Phase Two inspection results are documented in Inspection Report 2002-18.

Phase Three of the inspection effort was designed to assess the Safety Culture Assessment and Monitoring Tools, the current status of the Employee Concerns Program, the Safety Conscious Work Environment and Safety Conscious Work Environment Review Team, and the tools planned to be used to monitor Safety Culture in the future.

Phase Three was specifically developed to provide the NRC's 0350 Panel with information necessary to effectively integrate information from all inspections to reach an overall conclusion regarding the Safety Culture at Davis-Besse.

More about that later, but first some administrative activities, if I might. The Phase Three Inspection has run from March 20th of this year through yesterday. And the Report Number is 2003-12.

Given the history and where we are as far as what the purpose of the Phase Three was, we put together a team that was composed of both NRC individuals, as well as consultants from industry.

The team members included Claire Goodman, who is a Senior Human Factor Specialist in the office, in the NRC's Office of Nuclear Regulation. Claire is an expert with over 30 years of experience in the areas of Human Performance, Organizational Effectiveness and Communications and Safety Culture at nuclear power plants.

As I indicated earlier, Jay Persensky, on my right, was a member of the team. He is a Senior Technical Advisor for Human Factors in the NRC's Office of Research. Jay holds a Ph.D. in applied psychology and has over 30 years of nuclear experience in the areas of Human Factors and Behavioral Science Technologies in the work environment.

Lisa Marie Jarriel of the NRC's Office of Enforcement was also a member of the team. She has over 21 years of experience in Nuclear Safety, Safety Conscious Work Environment, and Employees Concerns Program implementation.

Rick Pelton joined us for a short period of time. He's a training and assessment specialist in the NRC's Office of Nuclear Regulation with over 35 years of experience in evaluating Human Performance Training and Root Cause Evaluations.

The two consultants that we had with us were John Beck, who is the Chief Executive Officer of a consulting firm specializing in Safety Culture and Safety Conscious Work Environment at nuclear facilities. John has over 36 years of nuclear management experience, serving as a Chief Operating Officer, Executive Vice President, Vice President and Director of Engineering for three different successful nuclear utilities. John also played a key role in the recovery of the Safety Conscious Work Environment at the Millstone Facility in the mid 1990s.

The other consultant that we had with us was Mike Brothers. Mike is the head of his own engineering and consulting firm. He is an expert in nuclear safety facility operations, including Safety Conscious Work Environment and Employee Concerns Programs. Mike has held a number of positions at nuclear utilities, including Vice President Nuclear Operations at Millstone. In this position, he was responsible for overseeing the recovery of the Safety Conscious Work Environment and safe operation of that facility.

I would like to take some time to go over, since the inspection that we did here, looking at Safety Culture, Safety Conscious Work Environment, Safety Conscious Work Environment Review Team and the Employees Concern Program, is significantly different than we have done at other facilities.

There was no inspection module that you can look up in our inspection manual that will identify to you exactly what we did. So, we developed our own inspection process that was reviewed and approved by the 0350 Panel. And so, you have an idea of the depth and breadth of the inspection activities, I would like to go through exactly what we were talking about as far as items here.

The inspection deliverables, as I indicated earlier, the special inspection was designed to provide the NRC's 0350 Panel with an evaluation of the processes used to assess the site's Safety Culture, the monitoring activities involved with improving Safety Conscious Work Environment, and the status of the Employees Concern Program, and an assessment of survey results.

Let me just take a minute and make sure that I'm coordinated with the slides behind me here.

The input from this inspection when combined with other inputs, for example, System Health Inspections, Program Review Inspections, Containment Health Inspections

and the Corrective Action Team Inspection, along with the RATI results that you've heard just previously, will allow the panel to make an informed decision on the effectiveness of the overall Management and Human Performance Corrective Actions. To that end, the following deliverables were expected from this team.

On the Internal Assessment -- let me back up. There were a number of areas that we looked at. Your Internal Assessment, the External Assessment, the integration of those two into a long term plan, the Safety Conscious Work Environment, Safety Conscious Work Environment Review Team, and the Employee Concerns Program.

In the area of the Internal Assessment, we were to provide an assessment of the input parameters, evaluation techniques, and methods to develop conclusions used in the Internal Assessment.

For the External Assessment, we were to look at the input parameters, evaluation techniques, and, again, methods to develop conclusions from the individual imputs.

From the integration of Internal and External Assessments, we looked at whether or not and how the benchmarking of your Internal Review against the External Review to see if there were any holes in the program.

For Safety Conscious Work Environment and the Review Team, the assessment, we looked at current and future

activities promote the open identification of deficient conditions, those programs defined to prevent retaliatory actions, and to monitor -- and your actions to monitor the effectiveness of those programs.

For the Employees Concern Program, we looked at the assessments that had been brought to the Employees Concern Program to-date, the methods used to review those issues, and resolve the issues. The team also, to the extent practical, provided assessment of the reason individuals are using the Employees Concerns Program.

There was one additional item that you will see, which dealt with measurements to monitor the effectiveness of all of the above. There will not be a separate section in the inspection dealing with that. It was integrated into each one of the previous areas discussed.

When we looked at the Internal Safety Culture Assessment, we basically looked at the appropriateness for evaluating the Safety Culture, the appropriateness of the monitored items, and we looked for any weaknesses that would limit the practice's effectiveness as a tool for long term evaluation of the Safety Culture at the facility.

In evaluating the External Safety Culture Assessment, we looked at the suitability of it for monitoring Safety Culture, including the questions that were asked, interview questions, actions observed by that

team. We also reviewed documents and looked at the sampling plan that your external experts had used in picking people to interview.

We looked at the implementation of that plan. We looked at the methodology used to take the results from the interviews, observations, and surveys, and how those were factored into conclusions. And we also looked at the results of the Safety Culture monitoring tools and the data collected to determine whether or not they were consistent.

We also looked in the area of what was called convergent validity. That being if I looked at what the interviews have told me, I looked at what surveys may have told me, what the documents tell me and say; are they all pointing in the same direction.

When we looked at the Internal and External Assessments, what we wanted to do is see, were the Internal and External in sync with the information that was being found, and how you took that information and transformed it then into a long-term process for monitoring the Safety Culture at this facility.

In the areas of Safety Conscious Work Environment, and the Safety Conscious Work Environment Review Team, we looked at the matrix that you were using to monitor the program's effectiveness. We looked at the performance in

the, your use of your policy on Safety Conscious Work Environment. We looked at the effectiveness of the training programs for your employees, contractors, and management. And we were looking for the effectiveness of the internal communications at the facility in those areas.

Then, finally, for Employees Concerns Program, we evaluated the matrix you were using to monitor the program, the quality of the investigations, and the confidentiality provisions of the program.

We used varying techniques in doing our evaluations. Those included as normal, independent review of documents, development and implementation of interview, a special interview questionnaire which we used to query about ten percent of the staff here on sight.

We did a comparison of the results of the questions that we had asked to the information that you were gathering in the Safety Conscious Work Environment arena. We looked at the implementation of the External Assessment Program through the interviews with selected people who had participated in that.

We also interviewed selected managers and senior managers. We observed both interdepartmental meetings, SCWERT, that's Safety Conscious Work Environment Review Team meetings, the Restart Readiness Review Panel meetings,

we observed two of those and one follow-up to there. For ECP, we actually looked at the case files up through the summer, late summer of 2003 in detail.

I talked a minute about the Restart Readiness Review Process. We reviewed Revisions 2 through 9 of that document in detail each time we received a new one. And then we looked at what were the, the various Safety Culture surveys doing and telling us as it came out, particularly those in March and November of this year.

That's the inspection process, and the approach that we took. I would like to now transition over to the observations. I will follow the same outline as far as the areas that we've looked at.

In the Internal Safety Culture Assessment Tool, the overall conclusion in this particular area was that the Internal Safety Culture Assessment Tool, tools in this case, are adequate and provide appropriate information to monitor the Safety Culture at this facility.

In this regard, we were including the Restart Readiness Review Business Practice, along with the Nuclear Oversight Survey, and the Employees Concern Program Survey; since none of them by themselves really encompass the whole of what you should have been, what you should be looking at. In connection, when you put all three together, it would cover the areas appropriately.

In reviewing these areas, we noted that the business practice developed, was an excellent initiative by the facility. Some of the areas that were of particular note were the areas; and these are specific definitions for the Restart Readiness Review Practice; the areas criterion attributes, those being the management staff and corporate entities. The criteria used to look at those areas and the individual items that were assessed, we found were generally in alignment with internationally recognized guidelines.

One of the positive attributes that came out of this was, and that I have not seen in very many facilities is, the meeting itself gathered all 21 organizations represented at the site, the managers of those organizations, put them in one room to be able to discuss what was the health of the organization overall.

The first meeting we observed took two full days, on just the Safety Culture portion of it. The second one took three, virtually three full days to accomplish. The dialogue between the managers and the challenges that you would find from organizations that you would think were disparate from what was being discussed, we concluded was very healthy and got a lot of good information out of it.

The weaknesses that we observed, some of the weaknesses that we observed in the process was Performance

Evaluation Criteria, while generally appropriate at what you call the white and green level, we found were often not appropriate at the yellow or red, particularly red/yellow level, without additional information being provided to understand the exact reason for that.

The originally designed green evaluations area were occasionally inconsistent with quality operations. Overall, we would have to say that the first Mode 4 assessment, we could not use without actually going back to the individual ratings for each organization in each area to understand what was going on.

And, that on occasion, one example, that the operating experience, which was one of the key items from the original Root Cause Analysis aspect of being a learning organization, hadn't been well represented in the original business practice when we had reviewed it.

The current status, looking at these positives and the weaknesses, is that you had taken a number of steps to improve the individual attribute rating standards. You implemented a management review for each area where you had yellows or reds. That, that worked well in accounting for the differences in organizations, both size and importance for that particular item, and then provided a report that assessed or looked at how do you reach the final conclusions. And where appropriate, you implemented, you

wrote Condition Reports and developed Corrective Actions.

For the External Safety Culture Assessment Tool, our determination was that it was an appropriate tool to provide valuable insights into the Safety Culture at the facility.

The tools, interviews, surveys, observations used for that to assess the Safety Culture were appropriate. The tools have a strong technical basis, since they were developed through extensive research. They have been widely used internationally and in numerous industries. The areas selected for review and evaluation were derived from internationally recognized and used guidance on Safety Culture monitoring.

The process was implemented as planned. All individuals that the inspection team interviewed felt that their answers would be kept confidential and the questions were understandable.

An opportunity was missed to enhance independence in this area when the individuals to reinterview were basically selected by the Utility as opposed to the Assessment Team at that time.

The results derived from the interviews, surveys, and observations that were reported to you were consistent with the collection, collected data. Independent assessments by my team were consistent with the external

survey's results.

The concept of identifying whether a number of diverse monitoring tools all point in the same direction was appropriately implemented, that is as I talked before, the convergent validity concept was appropriately used. Any outlayers that were identify were not included in the combined data.

The final report provided information to you that could be used to focus efforts to improve the Safety Culture at the facility.

In the area of Safety Conscious Work Environment, your efforts to improve the Safety Conscious Work Environment at the staff level, we find to have been effective. Very few individuals provided negative feedback regarding their personal understanding of their responsibilities and obligations to report safety issues.

Further, most individuals felt free to raise concerns. Individuals were also aware of the various avenues available to them to raise issues, that being their immediate supervisor or manager, the Corrective Action Program, the Employees Concern Program, or the NRC.

However, we have not seen the same level of positive feed, staff feedback related to the management commitment in this area. Our observations, interviews, along with your survey data indicate, in general, managers have not

understood or internalized the basic Safety Conscious Work Environment concepts.

Some of the things I would like to point out as observations in this area. The matrixes that you are implied -- or implementing are appropriate. All of the managers and operators, Operations Department, I believe, have received specific training in Safety Conscious Work Environment. Our review of the training documents indicated that they were very good and that training was appropriate.

We did note that the training of the staff is not, has not been as vigorously pursued as we would have hoped; however, the training is scheduled for 2004.

While appropriately training, like I said, while appropriate training was provided to all managers, interviews with managers indicated that many had not appropriately internalized the message, as I had mentioned before. Specifically, the areas of what constitutes an adverse action, and what constitutes protected activities, didn't seem to be well understood.

Surveys; the recent survey information was more negative on independence and confidentiality of the Employees Concern Program than we had seen in the past. And the survey was more negative on managers dealing with concerns brought to them. I think the survey data also

indicated, as I had indicated, noted earlier, that most individuals at this site, understand their responsibility and obligations, and indicated that indeed they would write safety concerns.

It's interesting that a higher percentage said they would raise safety concerns and a slightly lower percentage indicated that they could do so without fear of retaliation. So, there is a group in the middle that say, "I'll tell you even though I'm not sure what you're going to do to me."

In the Safety Conscious Work Environment Review Team, commonly called SCWERT, if I slip up along here somewhere. The bottom line on a conclusion there is we can not say that the Safety Conscious Work Environment Review Team can protect the environment at Davis-Besse. That is not to say that they can't, we can't make the positive statement that they can.

That is based on, that the effectiveness of the program is self-limiting; and, therefore, the potential exists that it will miss issues that could have a negative impact on the site's Safety Conscious Work Environment. Why do I say that? There are basically two items that limit the effectiveness, potential effectiveness of this program; one being that it does not include contractors, review of actions for contract personnel prior to the

action being taken; and as we've mentioned before, the managers do not have a broad understanding of what adverse action is.

In the area of the Employees Concerns Program, we found that it functioned well between January and November of this year when it was in place. The investigations were thorough and survey results indicated general acceptance of the program by the staff.

One concern we have at this time is the program's ability to imagine issues in a timely manner in the future because of the organization size. We do understand that provisions are being put in place to bring in contractors where necessary to support that organization.

General observations, that there were improvements seen over the Ombudsman Program that had been in place. The investigations were generally acceptable and timely. There was a concern raised on the use of individuals in the ECP program as consultants for managers. The concern there is, if the manager asks an ECP person, is this an appropriate action or what should I do, the action is taken, that individual really has no independent place now to raise the case. The ECP program that would have been an appropriate place to go has been compromised because of consultations up front.

The matrixes used to monitor the area are

appropriate. I should say were appropriate.

In the area of the Long Term Safety Culture Monitoring, that program, unfortunately because of some of the material associated with it not being finalized at this point, we cannot make an overall assessment at this time.

It is not something that would limit the restart of the facility. We will be back to review it. We did note that it really encompasses about five different items; that being a monthly performance monitoring, the surveys done by the Nuclear Oversight Organization, the Employees Concerns Program Surveys, the Restart Readiness Review Process, and we also noted that you have planned for late in 2005 to bring in an external organization to do an independent assessment.

MR. MYERS: Right.

MR. WRIGHT: Overall conclusions. The assessment tools and programs to address Safety Culture and Safety Conscious Work Environment, well beyond, were well beyond any sort of regulatory requirement.

Overall, we found that the tools being used to assess the Safety Culture at Davis-Besse were adequate and appropriately implemented. Further, based on the independent inspection activities that I have previously described, we have concluded that the output from these

tools provided valuable and appropriate insights into the Safety Culture at the site.

Based on the input from these tools, we have determined that a significant improvement in Safety Culture and Safety Conscious Work Environment has occurred on a site-wide basis; however, a recent survey taken in November of this year, calls into question the effectiveness of some of the Corrective Actions that were required by 10 CRF Appendix B Criterion 16, which stemmed from the Management and Human Performance Root Cause Assessment made -- calls into question how effective those Corrective Actions have been.

We are specifically concerned with the declines between March and November of this year in Operations, Engineering and QA and significant areas related to safety, safety and schedule and cost, as well as Safety Conscious Work Environment.

One of the items you just sat through, the Restart Readiness Assessment Team, we believe that a number of the performance deficiencies -- this is based on a preliminary review -- that a number of those performance deficiencies can be attributed or considered as symptomatic of the underlying problems shown in the survey.

The team has concluded that absent an understanding of the conditions that caused the declines, we do not have

reasonable assurance in the quality and consistency of future performance; and, therefore, we are unable to make a positive recommendation to the 0350 Panel regarding restart of the Davis-Besse facility.

To that end, and we've already talked, we've already heard this a little bit, we are requesting that you provide a detailed assessment of those areas that exhibited a notable decline. The assessment should be of sufficient detail to allow an understanding of why the different organizations responded to the, in the declining areas. And the assessment should include Corrective Actions where appropriate and measures to monitor their effectiveness.

Following receipt of that and evaluation of your assessment, we plan to conduct additional inspections in this area to gain the confidence that we need to make a recommendation to the 0350 Panel.

Before I conclude this, I would like to ask if there are any comments that members of my team, who were either on the phone or Jay, if there is anything additional you would like to add?

MR. PERSENSKY: No.

MR. WRIGHT: I think Lisa may be on, I don't know if she can get through.

Lisa? Lisa, can you hear me?

I guess we have some technical difficulties.

MS. JARRIEL: Geoff, can you hear me now?

MR. WRIGHT: Yes. I can. Thank you, Lisa. It worked. Is there anything that you would like to add specifically? As I indicated, Lisa was our expert specifically in Safety Conscious Work Environment and ECP programs.

MS. JARRIEL: No, I don't have anything to add, thank you.

MR. WRIGHT: Thank you, Lisa.

Before absolutely concluding this portion of the meeting, I would like to thank all three of my teams of which there were actually three separate groups that looked into these three areas, and the many FirstEnergy and FENOC personnel that supported us.

The first phase of the inspection started about, you know, in the second quarter of last year. So, we've been at this for almost 18 months, which means for some of the resumes that I gave you, I would actually have to add probably a year's worth of experience at this point.

We have received outstanding performance, or outstanding support, I should say, from this organization in all aspects of that inspection activity.

This concludes my presentation regarding the observations and conclusions from Phase 3 Management and

Human Performance Inspection.

Jack, would you?

MR. GROBE: Yeah, thanks, Geoff. I just have a couple of comments and observations.

As Geoff indicated, there are no NRC inspection procedures for this area. This is not an area that the NRC normally looks at. We have regulations that require utilities to operate nuclear power plants in a quality fashion. Those regulations are contained in 10 CRF 50 Appendix B.

Geoff highlighted one of those regulations, which is Criterion 16, and that requires that Corrective Actions for conditions adverse to quality be taken and be effective.

The regulatory foundation for this inspection was that requirement. And we were out here to understand what actions FirstEnergy was going to take to correct one of the significant root causes that they identified and communicated to us in August of 2002, that resulted in the degradation of the reactor head, and that was specifically an inappropriate focus on productivity at the expense of safety margins.

I think I simplified that with just a few words, much more simply than you articulated to the audience.

The NRC does have regulations, as I mentioned, in Appendix B regarding quality. Also at 10 CRF 50.7

regarding the prohibition of retaliating against individuals for raising safety concerns. In addition, the commission has expressed the policy statements, our expectations in the area of Safety Conscious Work Environment and Safety Culture are also addressed in those policy statements.

The regulatory approach and focus of our inspection programs is what we call Performance Based Inspection or Outcome Based Inspection, where we look at the performance of the organization and then through Appendix B go back and look at what the root causes might be of performance problems.

As Geoff indicated, by and large, the programs and processes that you put in place to assess the Safety Culture and Safety Conscious Work Environment at your facility are well structured and founded. As he indicated, I think one of those processes went through ten revisions over the past many months, so it's been refined many times; and the outcome of that refined process is an effective tool to assess the organizational effectiveness in the organization.

Geoff made a number of comments regarding those tools and ways in which they could be enhanced. Those are not regulatory requirements and they're simply provided by a team of highly capable and competent people in these

areas as observations and comments for you to consider.

There is one issue though that is necessary to address. One of the handouts that Geoff provided was a brief summary of some of the data from a survey that you conducted of your staff in November. And there is only a little bit of the data. The overall set of data from that survey is very comprehensive, but this is just a brief summary of some of the areas where we saw declines in performance. I want to emphasize that these numbers are your numbers, they're not ours.

MR. MYERS: That's right.

MR. GROBE: They are percentages of negative responses to the various questions, and the questions have to be read carefully to understand what the data is saying.

There are no requirements to have these types of surveys or to have any level of performance per se in each of these areas. Our concern is not the specific values of the data; our concern is that there has been a notable decline in several departments in several areas between March and November.

Some of these departments had significantly better performance or indications of performance in the survey in March. Some of these departments actually improved in a number of areas. There are many other departments and many

other areas of the survey where performance was strong; however, we don't understand what has caused the declines in these areas and these departments.

The particular departments highlighted on these surveys, this table, are the Operations Department, Plant Engineering, the Maintenance Department, and Quality Assessment Department. There were other, as I said, there is other departments with data that is also declining, however, these were the ones that were most notable by our team.

As I mentioned, we don't understand what has caused these declines; and until we understand that, it is difficult to express a view. The panel has found it difficult to express a view on the future success of the organization in resolving one of the root causes to the head degradation.

I understand, Lew, that you've also, you also anticipated on the 29th, you will be able to provide us some additional information regarding this data and what it means; and particularly, I would hope that you would address your appreciation of what caused the performance decline in these areas, the indicated performance decline, if in fact it is a performance decline; what actions that you've taken in the past were not effective; what activities you may have taken that contributed to this

decline; what actions you're going to take in the future that will address the issues that you identify, and why you believe in the future those to be effective.

The 29th is only ten days from now, and between the inspection that you presented earlier, the Restart Readiness Inspection Team Inspection and this inspection, there is a number of issues that need studied and additional information from the organization.

We certainly will not have an opportunity to review any of the information that you're going to present on the 29th before the meeting.

MR. MYERS: Right.

MR. GROBE: So, that meeting though will be our first step in continuing dialogue and assessment in these areas with you. I anticipate that we'll have a number of staff available for that meeting, and that they will be either available in person or on the phone. I anticipate that we'll have a lot of questions for you, and there will likely be additional work that you will need to do and could likely be additional work that you would need to do following that meeting, before progress could be assessed and a decision could be made as to when it would be appropriate to schedule additional inspections and schedule a restart meeting.

Christine? Others? Bill, do you have any other

comments? Christine?

MS. LIPA: No.

MR. GROBE: Lew, at this point, why don't I turn it over to you; do you have any comments?

MR. MYERS: Yes, I do. I thought about this, this area last night, and the journey that we've been on in the past couple years, year and a half or so, you know, concern identifying a safety problem, starting at my level and all down through the nuclear organization. I believe when you take a job in this field as a nuclear worker, you accept a responsibility. That responsibility is that you identify any safety problem, that personal responsibility we accept as nuclear workers, if we have one.

From a management standpoint, what we have to do is provide multiple methods of identifying those problems and allowing our employees to raise those concerns through our normal management process, through the Corrective Action Process, Employees Concerns Process, if necessary to the NRC. I would have been much happier today if somebody said something about the reactor vessel head to the NRC, than not brought up at all; much better, you know.

That being said, this is a journey, you know. It's our responsibility. Safety Culture is a term. You know, I

started in this industry a long time ago, back in '67. And, who would have thought at the end of my career I would be talking about Safety Culture. Maybe the most important thing I've learned in my career.

If you would have asked several of us sitting this room today, the difference between Safety Conscious Work Environment and Safety Culture a year and a half ago, we would have given you the definition of Safety Conscious Work Environment, you know, pretty confident of that.

Today we have gone a long way. We have a model of Safety Culture. I was at our other plant the other day watching us do our assessment and it's a leading model in industry that we're using. I'm extremely proud of what we have done in that area. And, it's another management tool that we can help be more effective at in operating our nuclear power plants and ensuring that we have the right standards and environments present.

Safety Conscious Work Environment is an important thing also. And everything that we do as management is received differently by different individuals. We think, you know, we went through a development, a discovery phase, an implementation phase, and a design phase, and now we're into the implementation phase.

What that does is puts stress on a lot of key departments, like Chemistry, Ops, HP, stuff like that, and

Maintenance, you know. We're seeing some of those stresses, because we've taken action now every day to drive getting the work done, you know, to get the NOPT Test done. Restart the plant, that's our focus now; where a year or so ago was walking down systems, you know.

What we've got to do is take this data, which we've already started. We've got a few hundred feedbacks already from our employees and what data means. We're having standdowns with each and every employee over the past day or so, because before this meeting, one thing I learned at Davis-Besse, if I haven't learned anything else, I always try to share stuff with the employees before it gets to the public meetings. That's one thing our employees feel very strongly about.

So, we met with all of our employees in about four different meetings through last night talking about some of the results in the survey and also the results of the Readiness Team before this meeting, and shared as honestly as we could with them our perception of where we're at.

Now, that's not to say we're through. We're going to continue over the next few days, we're having some outside help come in and help us look at the data, and understanding of, we'll probably do some more interviews; and then we'll figure out what we want to share with our employees and you, and our Corrective Actions that we need

to take going forward. But we think that's healthy. We think it's healthy.

Overall, the survey, once again, if you look, I would share that, that the overall results went up, but there are some areas that we need to go look at. That's what managers do. We'll do that. We'll take it seriously. We'll bring in the best help we can. We'll give you the best information we can on the 29th, and we look forward to that meeting.

And, you know, I'll tell you, this model that we're using for Safety Culture and the Safety Conscious Work Environment stuff may wind up being the most important thing I've done in my career. So, I think the past two years I look at, this has been a learning experience for myself. So, I appreciate the effort, and look forward to this effort going forward.

MR. GROBE: Okay. Thanks, Lew.

Geoff, Jay, any other comments?

MR. WRIGHT: None.

MR. GROBE: Christine? Bill?

MS. LIPA: No.

MR. GROBE: At this point, this would conclude the business portion of the meeting. What I would like to do is take a few minute break, and

then go into the question and answer process. We'll take questions here in the room first, and then go to the phone lines and circle back and forth to make sure that all questions are answered.

So, let's take a ten minute break. It's five to 11. We'll reconvene at 5 after 11.

(Off the record.)

MR. GROBE: Thank you very much. This is Jack Grobe. Before we get started I want to correct some misinformation that I provided. The meeting on the 29th is at Oak Harbor High School at 6:00 in the evening. We anticipate several hours of dialogue with FirstEnergy, and it will be just like all of the meetings we've conducted where there will be an opportunity for public questions and comments.

We will have that meeting transcribed. The transcription will be available shortly after the meeting; however, we will not have telephone hookup for that meeting. I don't believe we have that capability at Oak Harbor. So, that was the information I wanted to correct.

At this time, what I would like to do is recognize one individual in particular. The Nuclear Regulatory Commission has maintained a very close relationship with the Ottawa County officials, officials of the State of Ohio, as well as federal elected officials who represent

the State of Ohio in the local districts here. And we have a representative of the State of Ohio here today who has been monitoring our performance of the Restart Readiness Assessment Team Inspection, as has the state and representatives here monitoring various other inspections over the last two years.

Sonya Eischen is in the audience.

Why don't you stand up, Sonya.

She represents the State of Ohio and has been observing our activities. We welcome their presence, and it's assisted us in keeping a very close communication channel open for the State of Ohio. So, thank you for being here today, Sonya.

Are there any other elected official or representatives of elected officials that are here in the room? I didn't see any.

Very good. Thank you.

We do have some 80 callers on the phonelines. We'll get to those in a minute. What I would like to do first is take any questions or comments from the members of the public that are here in the audience today.

If you could approach the microphone and speak very clearly and loudly into the microphone. Also sign in, if you would, so we have a record of who you are. Thank you.

DR. WIZNER: Good morning. My

name is Doctor Dan Wizner. I'm a retired geography professor. I live in Oberlin, Ohio, which is 60 odd miles downwind. And I'm here as a citizen, but also because over the last 37 years I've worked, in fact, in the area of disaster management.

This year alone, 2003, I published three books, a second edition of my textbook written for Rutledge in London about risk; a book in furtherance of higher education project, an instructor's guide, called Vulnerability Approach to Emergency Management; and a book for the World Health Organization I co-edited called Environment in Health and Emergency Disasters.

So, I want to make, I simply want to remind the Commission of two truisms, and then reflect a little bit on Safety Culture very briefly.

Safety Culture is in fact my prime professional expertise. I participated with several UN agencies during the International Decade for Natural Disaster Reduction, 1990 through 1999.

The two truisms are simply that, as Mr. Grobe said earlier in summary, inappropriate focus on productivity as opposed to safety; that's the phrase he used more or less -- I'm paraphrasing; I would assert is inevitable, is inevitable.

We're living in a period of increasing

privatization, and if I may use the C word, we're living in a Capitalist society, and the pressures therefore on this plant will be unrelenting. All right. That's first truism.

The second is, as most of you have engineering backgrounds, you know quite well that tightly coupled complex systems necessarily produce falls and anomalies; and as Charles Perot at Yale University says in his book, Normal Accidents, they almost inevitably fail in one form or another. That's the second truism.

Now, what's this got to do with Safety Culture? Well, clearly, it just makes it extremely important, so I agree entirely with Lew Myers, who said very well that in his long career this may be the most important aspect of the restart process for him and for everyone else.

Those two truisms mean that Safety Culture is what stands between my grandchildren, my neighbors, and a plume of radioactivity.

Now, I simply want to remind you of the language used by the Nuclear Regulatory Commission in its February, 1997, ten-page publication on Safety Conscious Work Environment. They, in fact, use very interesting language to describe a Safety Culture. They talk about the maintenance of a safety ethic at all levels, from page 3 of the, February 1997 document.

Quote, "Safety ethic at all levels that is characterized by inherently questioning attitude, attention to detail, prevention of complacency, the commitment to excellence and personal accountability in safety matters."

That sounds pretty good to me. Although, this plant is part of a large corporation called FirstEnergy Corporation. And, I know that, that the Nuclear Regulatory Commission has no jurisdiction over, for instance, the electricity grid operations of FirstEnergy. However, yesterday, when I was in the Public Relations Office in this building, I saw a sweatshirt on the back of someone's chair. It said, "Blame Canada" "Blame Canada".

Now, you probably all know that that refers to a dispute that's been going on, that's actually, I think it's successfully settled now by various commissions; whether or not the energy outage in August that plunged 50 million people in North America in darkness was the fault of operators in Canada or the U. S., or in particular, the fault of FirstEnergy Corporation operators.

And, I think that as a symbol of what this plant is up against, as it, as it tries to show to public servants, that is my servants, you on the commission, that it's ready to restart, the sweatshirt is really quite telling. It's really quite a powerful symbol.

FirstEnergy Corporation did not train its operators

properly, the grid operators. Their computers malfunctioned. All right?

Now, at the core yesterday, Mr. Bezilla told me, that the core of safety system here rests essentially with the analysis of faults. Now, it's about a four-fold process, as I see it. You've got to be aware of the potential problems in the first place. We heard for nearly an hour this morning between 9 and 10 that that awareness is not there yet. Maybe it will get there.

But then these things have to be reported. Of course, that's where the second team comes in on the Safety Conscious Work Environment, the Employee Concerns Program, et cetera.

But then, this important step of analysis, because you don't act with all ten thousand, approximately, ten thousand reported anomalies each year, a number that is a gross estimate, one that Mr. Bezilla shared with me yesterday. Okay? You simply can't act on all of them. So, what do you do? You have to analyze them.

Well, I asked Mr. Bezilla yesterday, I said, "Gee, that must take a lot of computational power. How many gigabytes of computational power do you have here on site? And how old are these machines?"

Turns out, if I'm not mistaken, he told me the machines are in fact off site. They may or may not be

maintained by a subcontractor. I don't know whether the Nuclear Regulatory Commission's brief has actually extended to looking at those computers that will be used to do trend analysis on these reported faults. The whole system will fall apart unless you do that.

MR. GROBE: Sir, if you could, we have a lot of people, I'm sure are interested, if you could wrap up your comments.

DR. WIZNER: Right, I'll wrap up with one more, one more concern.

I talked about a sweatshirt. All right? And, the point, the point here is that, FirstEnergy Corporation, unless it has a Safety Culture from the top, from the Board of Directors right the way through all of its operations, right, it's not, you're not going to successfully have a Safety Culture here, you cannot, unless you stage a coup and you set yourself up as an entirely different entity. That's the first point.

The second concerns a commitment banner. Like the sweatshirt. This is a flyer I obtained yesterday that invites people to a meeting that was supposed to take place yesterday. And, many of them, I guess are here today. It invites people to come along to the cafeteria and sign and autograph the commitment banner; "We're ready. We're ready. The plant's ready, so are we."

I submit -- this sounds anecdotal and perhaps silly, but I submit as someone with 37 years of work internationally in this area, that there is no worker in this plant in their right minds who in this high school pep rally environment, "We're ready, We're ready, Let's sign the commitment banner", will stand up and say, "Well, wait a minute, maybe we're not ready."

I think this is the elephant that's actually in the room that nobody's talked about. All right? You can have all the fine details of employee, employee communication systems and anonymous phonelines and all the rest of it, but it has to do with the overall culture in the plant. And I am very much concerned with this whole notion of a commitment banner and getting everybody out to the cafeteria to autograph it, so they can put it forward.

MR. GROBE: I really appreciate your comments, sir, and I would like to make a couple comments.

DR. WIZNER: Right. Thank you very much.

MR. GROBE: A couple of observations of things that you may not be familiar with in our regulatory environment that is different than the areas that you've worked, our regulations require action on every deficiency identified that concerns safety. So, if there

is ten thousand, or five thousand, or one thousand, it doesn't matter, every one needs to be fixed. And, that's clearly in our regulations, and it's something that we focused on in our inspections.

Secondly, you made some very valid observations, and largely, I agree with your observations, that any time you have complex technical systems, it's, the systems are challenged to perform successfully because of their complexity.

And for that reason, the regulatory structure, Nuclear Regulatory Commission in ensuring safety to nuclear power plants, ensures on diversity and redundancy in all those systems; and ensures on duplicity -- duplicate reviews and validations of all design information and evaluation of those systems.

So, there is multiple layers of protection; and within each of those layers, there is redundancy and diversity in the equipment that is intended to protect the public.

You indicated that there is commercial pressure which is in direct conflict with a safety focus, and that's absolutely true. Operating a business in a commercial environment, a competitive environment, necessarily creates conflict with Safety Culture. And, that's why there is organizations within FirstEnergy; for example, the

quality -- Nuclear Quality Assessment at the corporate office and at the site, as well as the independent Onsite Review Committee that evaluates the performance of the organization in an ongoing nature, as well as the Offsight Review Committee, which is experts from other organizations that continuously evaluates what's going on.

And, FirstEnergy went a step further and created a group that they call the Restart Oversight Panel, which was all independent experts, both from the Nuclear Regulatory Commission, former employees of the Nuclear Regulatory Commission, as well as outside experts from the industry, both current employees of various utilities and former employees of the industry, to ensure that there is a proper balance.

We're in a situation right now, what I would describe as a check and adjust situation. There has been significant progress made over the last 22 months. There is some inconsistencies in the outcome of the actions taken by FirstEnergy. We need additional information regarding what's causing those inconsistencies.

We certainly don't regulate by banners and sweatshirts. I think what you saw today was two teams of exceptionally capable individuals that were brought to bear on this problem. And we will continue in a methodical process of bringing the right experts with the right

capabilities to assess what FirstEnergy is doing.

Our focus has always been on safety and will continue to be there. And I can assure you that this plant won't restart until the Oversight Panel makes recommendation to the NRC management that it can be safely restarted and operated.

Just one more observation, and we'll go on to another comment. The nuclear power industry in the United States is the largest in any country in the world. We currently have 103 reactors that have -- excuse me, 103 reactors with operating licenses, 102 of those are operating today. The safety performance over the last two decades of those nuclear power plants has continuously improved, and is setting standards in the world regarding safety.

Your observations regarding the inherent conflict between competitive environments and safety focus are absolutely on target, and that's why it requires the continuous diligence that you so carefully quoted from our publication. I like it when people quote back our publications to us.

Those attributes of a safety focus are essential, and are in place, and are resulting in extraordinary safety performance in the nuclear power industry in the United States, and we'll continue to evaluate those attributes

here at Davis-Besse prior to restart of this plant.

Is there somebody else here in the room that has a question or comment?

MS. HIRSCH: My name is Judith Hirsch, I'm a 27 year employee of Davis-Besse, and I would like to respond to one comment. The gentleman made a comment that he does not believe there is any employee at Davis-Besse that would have the courage to stand up and say this plant is not ready.

I would like to disagree with that. I believe there are a number of employees here who would do that. I would do that, and if you read the Condition Reports that are written every single day at this site, you will find a large number of them where employees are raising concerns; those concerns are being addressed; and those concerns are being answered.

Thank you.

MR. GROBE: Thank you, Judy.

Other questions or comments from here in the room?

Okay. Very good. We'll come back, if you have a question or comment, think about it, we'll come back to the folks here in the room in a few minutes.

What I would like to do now is go to the phonelines. Operator, if you would let us know if there is anybody on the phone that has a question or comment, we

would be glad to take that at this time.

OPERATOR: Thank you, our first question comes from Jim Pulsen with Newberg News.

MR. PULSEN: Mr. Grobe, I've been listening. I was wondering if you could be a little bit more specific. FirstEnergy has basically been held against permission to restart by the end of the year. Doesn't sound like it, but I wonder if you could offer a little more insight on that.

MR. GROBE: Yes, I can provide insight. The NRC will not be considering restart of the Davis-Besse facility before the end of the year.

MR. PULSEN: But beyond that, you're not sure.

MR. GROBE: Well, on the 29th, you will be getting some additional information from FirstEnergy. The issues that were identified this morning are difficult issues that require careful study. And, Mr. Myers from FirstEnergy has indicated that they will be prepared to provide some information to us on the 29th, and that will be our first step in receiving that information and evaluating it and determining what further actions are necessary on the part of the NRC to evaluate the performance at Davis-Besse before restart.

MR. PULSEN: Is the procedure

for NRC approval the same as it has been, it goes from inspection committees upstairs.

MR. GROBE: Yes. There is, we've been following a methodical process that's outlined in our internal procedures. It's called a Manual Chapter 0350 is the number. We've been following that process for about 21 months, I think now, and we will continue following that same process.

MR. PULSEN: Thank you.

OPERATOR: Thank you. Our next question comes from Paul Patterson with Glen Rock Associates.

MR. PATTERSON: Good morning. How are you?

MR. GROBE: Just fine.

MR. PATTERSON: What I wanted to ask, I guess sort of a follow-up on that. I guess the next time we're going to see the ability of the company to address some of the Safety Culture issues is on the 29th, but it sounds from what I heard today that there is probably going to be an additional meeting associated with these Safety Culture issues. Is that a reasonable assumption?

MR. GROBE: Well, there will be as many meetings as are necessary for us to get the

information we need. We have routine public monthly meetings, the 0350 Panel does, and we will continue those. Our next one is scheduled for January 13th. And, I believe the February one, the date is not finalized yet. But those schedules are available on the NRC Web site, and so we'll be meeting on a regular basis.

If we need specific meetings on specific topics, those will be scheduled and conducted. We generally give ten days advance notice of all of our meetings, so there is plenty of opportunity for public access. And we have done something unique on this project, and that is virtually all of our meetings are transcribed. And if we conduct a meeting outside of this immediate area, we try to provide a phone link similar to this one.

We recognize that this meeting might be of significant interest to folks, and it's close to the holidays, so we provided a phone link on this meeting also, even though we're here in the local area of Ottawa County.

MR. PATTERSON: I think it's great that you have this link, but just to get a better idea of the 29th; it sounds like because the issues are so complicated, et cetera, we should assume that the 29th meeting won't resolve, won't probably resolve enough issues in order for there not to be additional meetings before restart.

MR. GROBE: I can say that, I don't know if there will be additional meetings before restart. There will certainly be a restart meeting, but there will certainly be additional evaluation by the NRC, and I would anticipate additional inspection.

So, we generally discuss those inspection results when they're ready to be discussed publicly at our routine monthly public meetings.

So, there will be additional meetings before restart as a minimum, the meeting that was required in our Confirmatory Action Letter, and call that the Restart Meeting. If there is a need for additional meetings, they will be scheduled and conducted.

MR. PATTERSON: Okay. And on the 29th, just so I understand, will the company be going to Mode 4 and Mode 3 at that point in time?

MR. GROBE: When the plant goes to Mode 4 and 3 is up to FirstEnergy. The NRC doesn't have any hold on that. And there has been nothing observed during these inspections that would indicate that the plant cannot go to Mode 4 and 3 -- excuse me. All of our inspections to-date indicated that the plant can go to Mode 4 and 3 successfully, if they choose to do that. It was done safely in September and October. There were a number of performance problems that required action, but the

evolution was safely controlled.

So, if FirstEnergy chooses to go to Mode 4 and 3, that's their choice. They can do that as they need to, to accomplish work, and check out the various systems in the plant. But --

MR. PATTERSON: But we shouldn't see that as basically going to start?

MR. GROBE: No.

MR. PATTERSON: No, okay. The start will take longer than that, will take obviously sometime past the 29th to be figured out what happened.

MR. GROBE: That's correct.

MR. PATTERSON: Thank you very much.

OPERATOR: Thank you. Our next question comes from Daniel Horner with McGraw-Hill.

MR. HORNER: Yeah. I just wanted to ask, Jack, if you could clarify a statement that was made at the beginning of the meeting after the RATI presentation.

You said, the inspections are really no safety issues, then a couple minutes later you said, this would have assurance, I think, when you said the plant will be able to restart safely, that there was a potential safety question. So, I think I maybe got tripped up on the

terminology, so if you could explain those two statements and how they fit with each other.

MR. GROBE: That's an excellent question, Dan. Thanks. You're starting to talk like a bureaucrat and use our acronyms.

The panel is challenged with a difficult decision; and that is, when does the panel have sufficient information to make a recommendation to NRC management that it has reasonable assurance that this plant can be restarted and operated in a manner that's consistent with our regulations and the plant will be consistently safe in the future.

The issues that were identified to-date during the two Exit Meetings caused questions. There are no safety issues that have been specifically identified. What I mean by that, we categorize inspection findings in different risk categories or safety categories. We use simplistically colors; green, white, yellow, and red. Well, there were no findings that were discussed today that would be greater than green from a risk perspective or a safety percent effective.

Not withstanding, these findings raised questions in our mind that the panel needs to understand before it can feel comfortable making the recommendation to NRC management that this plant is ready to restart.

MR. HORNER: Okay. Another quick one. On the scheduling thing, your response to the previous question; so, in other words, there has to be, there certainly has to be a minimum of one more meeting, which is the restart meeting, which was to have been, which was planned on the 29th, but that has to take place in addition to any of the monthly meetings, and there may or may not be additional meetings according to what sort of responses FENOC provides and what further inspection and evaluations are required from the NRC. Is that basically right?

MR. GROBE: I believe so. I'm a little concerned, and maybe I could talk about this for just a moment. I'm a little concerned with the focus on meetings. The Confirmatory Action Letter requires that FirstEnergy committed to conducting a meeting, which we call a Restart Meeting. That's going to be near the end of this process prior to restart.

The focus of that meeting is kind of a wrap-up meeting, where FirstEnergy will present in a holistic way what caused the problems in the long term shutdown at Davis-Besse, what actions were taken to resolve those problems, why they believe those actions have been effective, and why they believe they're ready to restart the plant.

That will likely be the last meeting before the NRC considers the question of restart. It's certainly a prerequisite for us to make a decision on whether this plant is ready to restart.

The meeting on the 29th is going to be the beginning of the dialogue and further inspection in the two areas that we focused on today. If FirstEnergy chooses to go to Mode 4 and 3, we will certainly observe that. We can get valuable insights and additional data on plant performance if they choose to go through those evolutions; however, I anticipate that there will be a need after we understand the information that we will begin to discuss on the 29th; after we have a thorough understanding of that, I anticipate there will be an additional meeting for inspection, both of the areas that we discussed this morning. And the panel has not identified those inspection plans yet.

Rick Skokowski and Christine will be working on what further assessments need to be made in the area of conduct of operations. And Geoff Wright and I will be working on what further assessments need to be made in the area of Safety Culture and Safety Conscious Work Environment.

Those inspections will occur after we have a clear understanding of the specific aspects of information that we ask FirstEnergy to be prepared to provide on the 29th.

And just to refresh your memory, those specific issues are:

What caused these inconsistencies in performance?

Why were the prior corrective actions not effective, not fully effective?

What additional actions if any are necessary to improve performance?

And how they will assess the effectiveness of those actions prior to a restart recommendation from the Utility to the NRC.

So, we're going to hear FirstEnergy's information. I'm sure we will have some questions. We usually do. And following our understanding of that information, we will schedule some additional assessments on site and those will all occur before the NRC would be prepared, along with the restart meeting, before the NRC is prepared to make a restart decision.

MR. HORNER: Okay. One more quick question, if I could. I know that the going to Mode 4 and 3 does indicate imminent restart, but is there, does FirstEnergy have a schedule at this point when they will go to Mode 4 and 3? It's been changed a couple times. What is the current schedule on that?

MR. GROBE: Dan, I think you would have to ask FirstEnergy that and you can do that separately.

MR. HORNER: Okay. Thank you.

MR. GROBE: Yep.

OPERATOR: Thank you. Our next question comes from Lou Dale Monte with the Correction Group.

MR. MONTE: Good morning.

This morning you've outlined a number of violations, as well as a bit of Davis-Besse personnel performance following safe procedures. I was wondering whether or not you could help me understand, and specifically looking through some of these open items, if you could detail for me maybe three or four of the more prevalent open items that would be absolutely necessary before the NRC could consider establishing another restart meeting.

MR. GROBE: I think I just did that. Let me again say, that the specific issues are not of unique safety significance. What is important to the NRC is why they occurred and what actions FirstEnergy will be taking to ensure that their people perform their safety activities in a manner that is consistent with their expectations and consistent with our regulations. So, that is the focus.

Why has the Corrective Actions to-date -- why have the Corrective Actions to-date not resulted in the kind of consistent performance that FirstEnergy expects and why

hasn't it resulted in compliance, consistent compliance with our regulations as both they and we expect.

MR. MONTE: All right. So, that they know one, two, or three of these items are safety significant.

MR. GROBE: None of these items are uniquely safety significant. They're indicators that there is something going on that we don't fully understand yet and we need additional information to understand what's going on.

MR. MONET: Thank you.

OPERATOR: Thank you. Our next question comes from John Funk with the Plain Dealer.

MR. FUNK: Okay, my question is, it was almost answered, but it's a simple one. Will the two teams, special inspection teams that reported today, will they stay on site or depart until after you decide -- well, until, or will they depart until after the meeting the 29th?

MR. GROBE: These inspections, both of them are complete, and these inspectors will be writing a report of their findings. We have not yet planned any further inspections. We need to develop those inspection plans to focus on our particular areas of concern.

What will be very helpful to us in planning those inspections will be receiving the information that FirstEnergy will provide on the 29th and any further dialogue that is necessary regarding that information. And then those inspections will be conducted.

MR. FUNK: Thank you.

OPERATOR: Thank you. Our next caller is Paul Patterson with Glen Rock Associates.

MR. GROBE: If you could repeat your name, that would be helpful for the transcriber.

OPERATOR: Mr. Patterson, your line is open.

MR. PATTERSON: It's Paul Patterson with Glen Rock Associates.

What I wanted to ask just briefly is, it sounds like from the assessments and all the evaluations which yet have to be made, that we're probably talking at least 30 days or so before a restart meeting, much less when you guys make your final assessment at the earliest for the plant to restart. Does that make sense just from a lay person's perspective listening to this?

MR. GROBE: No. What I can tell you is that the NRC will continue to evaluate Davis-Besse performance in a methodical and well

articulated public fashion.

That was a complex sentence, wasn't it?

We do not focus on schedule. Schedule is not a concern to us. I appreciate that it's an important concern to others, but what's important to us is the decision we have to make as to whether or not there is reasonable assurance that this plant will be consistently operated in a manner which assures public health and safety.

Prior to authorization of restart, the Davis-Besse Oversight Panel has to make a judgment in that area and make a recommendation to Senior NRC Management, and they will evaluate that recommendation. And I'm sure they will have questions for us, and the final decision will be made by my boss, Jim Caldwell, who is the Regional Administrator in Region III in Chicago, Illinois.

Part of that process will be a public meeting that we call a Restart Meeting, and that will be a further information gaining meeting. And we'll get to the point of doing additional inspections when we're satisfied that we understand the information we've requested on the 29th. And when those inspections are complete, we can make a judgment as to whether or not we're ready to take that next step, which would be scheduling of the Restart Meeting.

So, it's, we're not focused on schedule, we're focused on safety. We're going to continue to perform our

responsibilities in a very methodical manner, and we'll continue to provide plenty of opportunity for public scrutiny and questions and answers.

MR. PATTERSON: That's very helpful. I understand that. I guess what I'm just trying to ask, if at all possible, if there is a minimum amount of time that we're talking about? I realize that you can't and certainly now probably focusing, as you said, how long it's going to take, but just from a lay person's perspective not being familiar with the process, I guess what would be helpful to some of us would be just an idea on a minimum of all these things that are probably going to be taking place, what the end might be from just the earliest it could theoretically be resolved.

MR. GROBE: I can't. What I can tell you is there has been a significant amount of work that's been done over the past 22 months, and the activities that need to occur to address these, the final issues, is a small fraction of that amount of work that's been accomplished. I can't speculate on what amount of time it might take to address these issues.

MR. PATTERSON: Thank you.

OPERATOR: Thank you. We have no further questions at this time.

MR. GROBE: Excellent. Are

there any other questions here in the room? Yes?

MR. GORE: I do have.

MR. GROBE: Could you sign in first and tell us your name.

MR. GORE: Judith Hirsch came up, I guess she's been here 27 years. My name is Kevin Gore, I've been here 5 days. So, you'll have to excuse me if I don't know too many people.

MR. GROBE: There is two bookends, right?

MR. GORE: Right.

Dr. Wizner came up and said basically he didn't know if safety would override productivity. I can tell you that I came from Salem Generating Station and Operations, and we didn't do any fire protection at Salem Operations. Apparently, here we do.

I guess, when you talk about a fire department, they don't start fires. When you talk about an Operations Department, they don't just operate the plant, both of those departments protect stuff. They protect from fires, they protect from nuclear accidents.

When you talk about a nuclear license, whether it's a Senior Reactor Operator License for a plant, Tech Specs, any design specifications, it's for the nuclear plant, it's not for sending electrons down a wire.

So, as an example for Doctor Wizner, I can say, if the reactor were on fire, would you put it out? Would you trust that the operators would put it out? That makes sense, they would absolutely do that. Same thing for a nuclear accident. If the reactor was undergoing an accident, would you stop that or would you worry about electrons going down the road?

I have every confidence that our people would take the corrective actions and stop the reactor from, putting out, you know, from starting a fire. At least common sense would dictate. And if we train our people for months and years to do the right thing, I believe that we will do that. I know certainly from my perspective, I would.

That's all I have to say.

MR. GROBE: I appreciate your comments; and I also have confidence at this point in time, that if there were a fire and ongoing nuclear accident, that the operators would respond to those things.

What's more important to us is several orders of magnitude below that, and that is the type of disciplined operating behaviors, procedural -- adequacy of procedures, and procedure adherence, safety focus, the questioning attitude that are just absolutely essential to prevent nuclear accidents.

There are safety systems, and operating procedures

that will mitigate an accident, but we also want to make sure that there isn't an accident to be mitigated.

So, any other questions or comments here in the room? Yes, ma'am?

MS. LUTMAN: My name is Dorothy Lutman, and I've been an employee here for almost 18 years. I'm a representative to and for everybody at Davis-Besse, in the last two years as the safety -- Plant Safety Chair Person. And I think a real good commitment to safety that we have shown, every one of the employees here, is the nine million eighty thousand eight hundred eighteen man hours on a lost time accident.

I'm also in agreement with Judy. I'm sure everybody here would stand up here, if they weren't nervous and my heart was pounding, to get the nerve to come up here too, and say that we would not be afraid to stand up and say if we saw something, recognized something to prevent the plant, as our CEO did at the beginning of this meeting. And, he -- a very good display of honesty, that we, if we're not ready to restart, we'll admit that. Hence, the delayed meeting.

As far as when I signed my name on the commitment banner, it was not as part of a pep rally, it was because of my personal promise and commitment to safety, to the plant, to be loyal, to give what I have to give in my own

job, in my own department. And when I sign my name, that's what that was.

Also on the comment about the sweatshirt. It wasn't a sweatshirt. It didn't say "Blame Canada". It was a little gift that now the Communications Group is going to know how much I spent; $4 for a T-shirt that said, "I blame Canada". And it would be a testimony that, as a nuclear professional, I still have a sense of humor. And that's all that that was, just a, just to show a sense of humor, as a joke, not as a banner or a statement from the Communications Group.

Thank you.

MR. GROBE: Thank you.

Any other questions or comments? Yes, sir.

MR. GORE: My name is Martin Gore. No relation to Kevin.

I'm with the Operations Training Group. I've been with them four years, equipment operator for approximately ten years before that.

What I would like to say is that these past three, four months, the Operations Training Group has undergone evaluations from the NOP/NOT Test. We've looked at observations out of our database. Many of the same issues that we are finding in Observations, was brought up in this panel.

We are continuing looking at the expectations that are expressed, which are relatively new as far as being written down. We are enforcing those within the nonlicensed operators, as well as the licensed individuals.

I will say that from the discussions with the, the information put out by the two inspection teams, that I'm sure more focus areas of training may be changes to our evaluation processes of the Operations Group from nonlicensed operators to licensed operators; may be a way to go to ensure that some of these expectations, standards, procedural compliance issues are addressed.

I would also say that with the number of modifications the plant has undergone, the number of revisions for these procedures that continually come out, it's not uncommon to see two revisions distributed in the same day.

So, it's all the amount of work and the amount of procedure revisions that are being in place. It is a very difficult opportunity for the operators to be successful. They are trying. I've observed the controlling activities. They demonstrate the proper behaviors. I observed the nonlicensed operators who just successfully completed all of their annual exams, performance examinations very successfully.

So, we are looking to improve and better our processes. Thank you.

MR. GROBE: Thank you very much for your comments. You bring up a good perspective. And sometimes when we comment on Operations' performance, people immediately perceive that as a criticism of individuals, and sometimes it is a criticism of individuals, but in most cases, there is a number of contributors to an activity not being successfully accomplished.

In some cases there is procedural deficiencies, in other cases there is work planning and scheduling problems. There is other activities that put unique or inappropriate stressors on the behaviors in accomplishing an activity, there's training.

So, there is a whole spectrum of activities that could be contributors. And, those are the types of things that we expect to get additional insight on, on the 29th. As to what it is that's caused this inconsistent performance and what actions need to be taken to shore that up.

Other questions or comments?

Yes, sir?

MR. ANDREWS: Yes, my name is Doug Andrews. I've been working here at Davis-Besse for 16

years. The last two years or so, since this issue with the reactor vessel head, I've been working in Quality Assurance and Quality Assessment Oversight. I also have 25 years in the United States Navy. And I have an understanding and a desire for safety.

I just want to say two truisms and then one comment for consideration. I think the first truism is that, Jack, I think you've expressed since the beginning that Davis-Besse will not start up until we have a Safety Culture and Safety Conscious Work Environment that's proper. I think you've been consistent in that stand. I think that the management understands that, and I think Davis-Besse employees understand that and appreciate that truism, that we are not going to start up until that's the case.

The other truism, I think, is that these 22 months have been very difficult for the employees here at Davis-Besse. They've been working very hard, putting in many hours of overtime, time away from their families that cannot be regained. It's been a hardship on us, and we want to start up.

Those two truisms then, I guess, lead to one comment. You mentioned that we have these surveys that the NRC seemed to think that these are pretty good indicators of our Safety Conscious Work Environment and Safety

Culture, the way that we are trying to figure these things out.

I guess the thought for consideration is that as people are filling out these surveys, and they keep in mind these two truisms, that we can't start up until we have a good Safety Culture and Safety Conscious Work Environment. And yet, being shut down is a hardship.

They have to answer these questions about our Safety Culture. They could say, "Yes, everything is fine. We want to start up. We're good to go. Let us start up", but instead, I think that perhaps the survey may indicate that the people are willing to raise concerns, to voice their concerns even at a personal hardship that we may still be shut down for awhile until we address those concerns.

So, this document that you have here, although it identifies some concerns and management is undertaking efforts to figure out why these numbers are the way they are and fix those, this document may also be a very good indicator of the Safety Culture here at Davis-Besse, that people are willing to suffer personal loss in order to do what is right and do what is safe.

Thank you.

MR. GROBE: That's a good perspective. Thank you.

Other questions or comments?

Okay. Let's go to the phone lines one final time.

Operator, any additional questions from your end?

OPERATOR: Thank you. Once again, does anyone have a question?

We have no questions at this time.

MR. GROBE: Okay, very good. Thank you very much.

With that, this meeting is adjourned. Thank you.

(Off the record.)

CERTIFICATE

I, Marie B. Fresch, Registered Merit Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified therein, do hereby certify that the foregoing is a true and correct transcript of the proceedings as taken by me and that I was present during all of said proceedings.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Norwalk, Ohio, on this 9th day of January, 2004.

Marie B. Fresch, RMR

NOTARY PUBLIC, STATE OF OHIO
My Commission Expires 10-10-08.